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Implementation of the Declaration of Commitment on HIV/AIDS and the political declarations on HIV/AIDS

Leveraging the AIDS response for United Nations reform and global health

Report of the Secretary-General

Summary

At the halfway point to the 2020 fast-track commitments agreed by the General Assembly in 2016, the world is making strong progress towards ending the AIDS epidemic by 2030.

There are gains across most of the 10 commitments made in the 2016 Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030. A majority of people living with HIV are accessing treatment and AIDS deaths have declined by one third since 2010, but the full achievement of the 90–90–90 targets by 2020 requires the expansion of community-led, people-centred approaches to HIV testing, immediate linkage to and retention in care, and adherence to treatment. The rapid roll-out of new and improved testing and treatment combinations is critical.

Gains in the global response to tuberculosis and HIV have led to a greater than one-third decline in tuberculosis-related deaths among people living with HIV. The elimination of mother-to-child transmission of HIV remains within our sights. Fewer children are acquiring HIV during childbirth. Nevertheless, the scale-up of paediatric treatment is off-track to meet the 2018 global target of 1.6 million children on treatment.

A growing number of countries and cities are showing that a combination approach to HIV prevention that respects and protects the rights of the most vulnerable can greatly reduce the incidence of HIV. Stigmatization and discrimination, gender inequality, poverty, food insecurity and other social inequities faced by people at high risk of HIV acquisition and people living with HIV constitute legal and policy barriers to service utilization and impede efforts to reduce new HIV infections. Global investment is also insufficient, nearly $7 billion short of the commitment made in the 2016 Political Declaration.

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AIDS is not over, but it can be. The global AIDS response has inspired innovations in global health, sustainable development and coordination within the United Nations development system. Moving forward, the joint United Nations approach to the AIDS response, the H6 partnership and the wider United Nations reform agenda are opportunities to accelerate progress towards the end of the AIDS epidemic and towards the achievement of the Sustainable Development Goals.

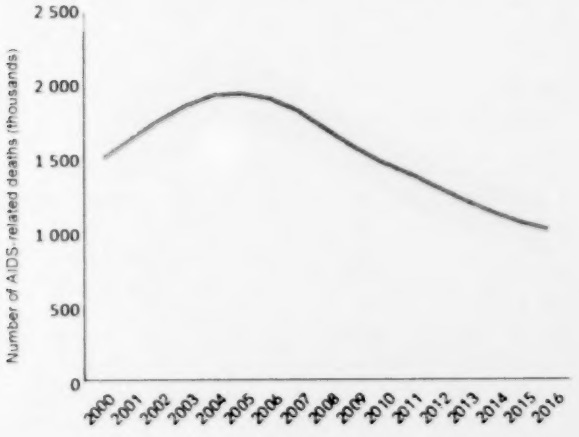
The present report sets out five recommendations: (a) mobilize an HIV testing revolution and achieve the 90–90–90 targets; (b) accelerate efforts to end tuberculosis and other co-infections and co-morbidities; (c) use the HIV prevention road map to accelerate reductions in new infections; (d) safeguard human rights and promote gender equality through people-centred service delivery models and supportive legal and policy frameworks; and (e) leverage the joint programme of the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the H6 partnership as global health accelerators and incubators for United Nations reform.

I. At the halfway point to the fast-track commitments

1. The 2030 Agenda for Sustainable Development includes a target to end the AIDS epidemic by 2030 (target 3.3 of the Sustainable Development Goals). The path to achieving this ambitious target was set by the Political Declaration on HIV and AIDS: On the Fast-Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030, adopted at the high-level meeting of the General Assembly held in June 2016, in which Member States committed to increasing and front-loading investments in national AIDS responses and massively scaling up coverage of HIV services. This fast-track approach is needed to achieve three milestones by the end of 2020: reduce AIDS-related deaths to fewer than 500,000 globally; reduce new HIV infections to fewer than 500,000 globally; and eliminate HIV-related stigmatization and discrimination.

2. The seventy-second session of the General Assembly coincides with the halfway point of the fast-track phase of the global HIV response. Epidemiological and programme data reported by countries show that the world is making strong progress. Steady scaling up of antiretroviral therapy has been the primary contributor to a one-third decline in deaths from AIDS-related causes since 2010, from 1.5 million [1.3 million–1.7 million][1] in 2010 to 1.0 million [830,000–1.2 million] in 2016 (see figure I). Bringing AIDS-related deaths below 500,000 by 2020 can be achieved through sustained expansion of services.

Figure I
AIDS-related deaths, all ages, globally, 2016



Source: Joint United Nations Programme on HIV/AIDS (UNAIDS) 2017 estimates.

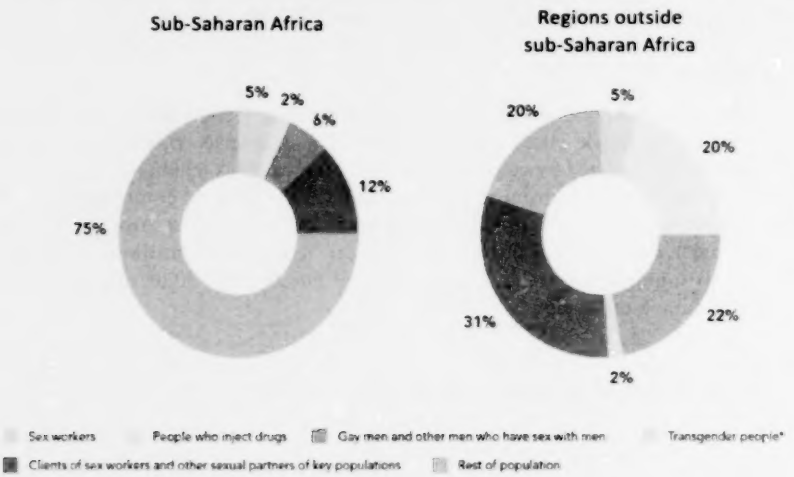
3. Nevertheless, over the same period, the annual number of new HIV infections (all ages) declined by just 18 per cent, from 2.2 million [1.9 million–2.4 million] in 2010 to 1.8 million [1.6 million–2.1 million] in 2016, an aggregate reduction that reflects uneven progress on HIV prevention, both geographically and among at-risk populations (see figure II). In high-prevalence settings, young women remain at

[1] Uncertainty bounds are calculated for each estimate. The bounds define the range within which the true value lies. Narrow bounds indicate that an estimate is precise, while wide bounds indicate greater uncertainty regarding the estimate.

unacceptably high risk of HIV infection. In East and Southern Africa, for example, young women (aged 15–24 years) accounted for 26 per cent of new HIV infections in 2016 despite making up just 10 per cent of the population. Young women (aged 15–24 years) in West and Central Africa and the Caribbean accounted for 22 per cent and 17 per cent of new HIV infections, respectively, in 2016.

Figure II

Distribution of new HIV infections, by population, sub-Saharan Africa and countries outside sub-Saharan Africa, 2015



Source: UNAIDS special analysis, 2017.

* Only reflects the Asia and Pacific and Latin America and Caribbean regions.

4. In lower-prevalence settings, most HIV infections occur among key populations — people who inject drugs, sex workers, transgender people, prisoners, and gay men and other men who have sex with men — and their sexual partners. Outside of sub-Saharan Africa, key populations and their sexual partners accounted for 80 per cent of new HIV infections in 2015. Even in sub-Saharan Africa, key populations and their sexual partners accounted for an estimated 25 per cent of new infections in 2015, underlining the importance of reaching them with services. Engaging and empowering these communities which are most affected by the epidemic and squarely addressing AIDS-related stigmatization and discrimination are key to getting below 500,000 new infections annually by 2020. A growing body of evidence shows that a combination approach to prevention that respects and protects the rights of the most vulnerable will deliver the fast-track results agreed by the General Assembly.

5. At this halfway point of the fast-track phase of the AIDS response, progress made thus far towards the commitments made in the 2016 Political Declaration inspires confidence. AIDS is not over, but a growing body of evidence shows that international triumph against one of the worst epidemics in recorded history can be achieved when Member States work together to use a location-population and life-cycle approach to expand the availability of services and address the social, economic and cultural barriers that block the most vulnerable from utilizing them.

Commitment 1

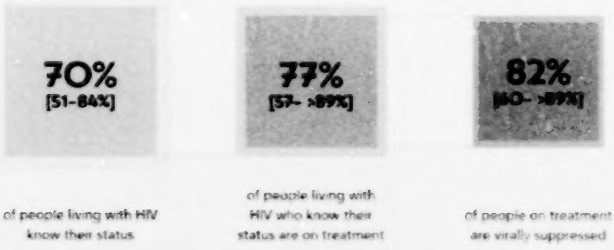
Ensure that 30 million people living with HIV have access to treatment through meeting the 90–90–90 targets

6. The latest epidemiological estimates and programme data reported to UNAIDS reveal remarkable progress on HIV testing and treatment. Access to antiretroviral therapy expanded from fewer than 1,000 people in 1990 to 20.9 million [18.4 million–21.7 million] people in June 2017. A major milestone was reached in 2016: for the first time, more than half (53 per cent [39–65 per cent]) of the 36.7 million [30.8 million–42.9 million] people living with HIV globally were accessing antiretroviral therapy. Recent progress has been guided by the 90–90–90 targets, which call for 90 per cent of all people living with HIV to know their status, 90 per cent of those who know their status to be on treatment and 90 per cent of those on treatment to have suppressed viral loads. Together, these targets reflect the importance of early diagnosis of HIV, immediate initiation of treatment and maximization of viral suppression among people living with HIV. Not only does treatment protect people living with HIV from AIDS-related illness, but it also greatly lowers the risk of transmitting the virus to others.

7. At the end of 2016, more than two thirds of people living with HIV globally — an estimated 70 per cent [51–84 per cent] — knew their HIV status. Among those who knew their HIV status, 77 per cent [57– >89 per cent] were accessing antiretroviral therapy, while 82 per cent [60– >89 per cent] of people accessing treatment had suppressed viral loads (see figure III). Individual countries, cities and communities in a diversity of settings have already achieved the 90–90–90 targets, proving that global attainment of these targets by 2020 is both feasible and reachable if gaps across the HIV testing and treatment cascade are aggressively addressed. The most recent data available to UNAIDS show that at least 18 countries have achieved or are close to achieving the target of 73 per cent of all people living with HIV having suppressed viral loads: Australia, Belgium, Botswana, Cambodia, Denmark, France, Germany, Iceland, Italy, Kuwait, Luxembourg, Netherlands, Singapore, Spain, Swaziland, Sweden, Switzerland and United Kingdom of Great Britain and Northern Ireland.

Figure III

Progress towards the 90–90–90 targets globally, 2016



Source: UNAIDS special analysis, 2017.

8. Several cities have also reached, or are close to reaching, the 90–90–90 targets; and the Sustainable East Africa Research in Community Health study has demonstrated that the 90–90–90 targets can be achieved in low-income, high-prevalence settings within just a few years through the engagement of community-based organizations and community health workers.

9. Available data suggest that people are starting treatment earlier.[2] Wider adoption of a treat-all approach and same-day initiation of antiretroviral therapy, as recommended by the World Health Organization (WHO), have been instrumental to progress. Viral load testing, which was rarely available in low- and middle-income countries just a few years ago, is rapidly expanding. Nearly half of all people on treatment in countries that reported data to UNAIDS in 2016 received a routine viral load test, improving the monitoring of treatment outcomes and helping to inform a timely switch to second-line and third-line therapy, when needed.

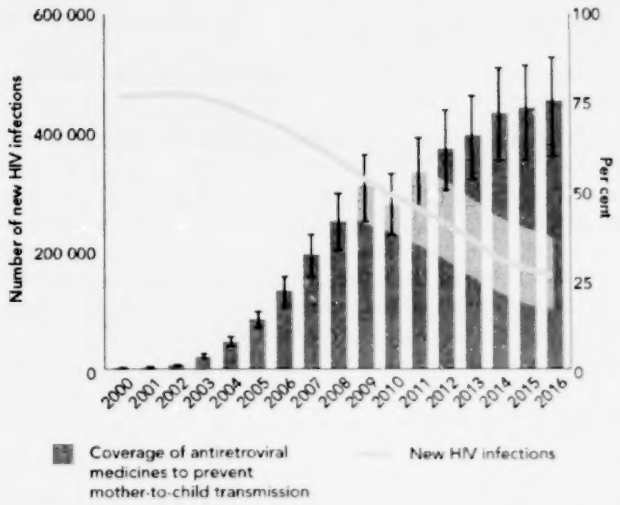
Commitment 2
Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018

10. Global expansion of maternal and child health services has achieved long-term gains in the health and well-being of women and children. Within that context, Member States committed in 2016 to the dual elimination of mother-to-child transmission of HIV and congenital syphilis. An increase in the number of pregnant women screened for syphilis and HIV and improved access to adequate treatment have seen the incidence of congenital syphilis fall from an estimated 780,000 cases globally in 2012 to about 660,000 cases in 2016. In addition, fewer children are acquiring HIV during childbirth. Globally, an estimated 270,000 [230,000–310,000] new HIV infections among children were averted during 2016 as a result of the provision of antiretroviral medicines during pregnancy and throughout breastfeeding.

11. The percentage of pregnant women living with HIV receiving antiretroviral medicines to prevent mother-to-child transmission or as lifelong therapy climbed from 47 per cent [38–55 per cent] in 2010 to 76 per cent [60–88 per cent] in 2016 (see figure IV). Since 2006, new HIV infections among children aged 0–14 years have declined by 61 per cent, including an 8 per cent reduction between 2015 and 2016. Nevertheless, about 160,000 [100,000–220,000] children still acquired HIV during childbirth or breastfeeding in 2016. Continued progress will be needed to achieve a 95 per cent reduction in new HIV infections among children by 2020, as called for in the 2016 Political Declaration.

[2] Andrew Auld and others, "Trends in prevalence of advanced HIV disease at antiretroviral therapy enrolment — 10 countries, 2004–2015", *Morbidity and Mortality Weekly Report*, vol. 66, No. 21 (2 June 2017).

Figure IV
New HIV infections among children (aged 0–14 years) and coverage of antiretroviral regimens to prevent mother-to-child transmission, globally, 2000–2016



Source: UNAIDS 2017 estimates.

12. Globally, an estimated 974,000 [857,000–1,013,000] children aged 0–14 years were on antiretroviral therapy in mid-2017. Antiretroviral therapy coverage is lower among children than adults (43 per cent [30–54 per cent] compared with 53 per cent [39–65 per cent]), however, and the total number reached is still well short of the Political Declaration target of 1.6 million children accessing treatment by the end of 2018.

13. Efforts to eliminate mother-to-child transmission of HIV and meet the 2018 treatment target for children living with HIV are part of wider efforts to give every woman, child and adolescent the opportunity to not only survive, but also to thrive and transform his or her community. These efforts are guided by the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) and supported by the H6 partnership (UNAIDS, United Nations Children's Fund, United Nations Population Fund, United Nations Entity for Gender Equality and the Empowerment of Women, WHO and World Bank) and the Global Financing Facility in support of the Every Woman, Every Child initiative.

Commitment 3
Ensure access to combination prevention options

14. A widening array of proven prevention options are available, including male and female condoms, oral pre-exposure prophylaxis (PrEP), voluntary medical male circumcision and harm reduction for people who inject drugs. A longitudinal study conducted in Uganda between 1999 and 2016 recently reinforced a body of evidence that shows that providing a combination of HIV prevention options, including antiretroviral therapy, successfully reduces the incidence of HIV infection.[3]

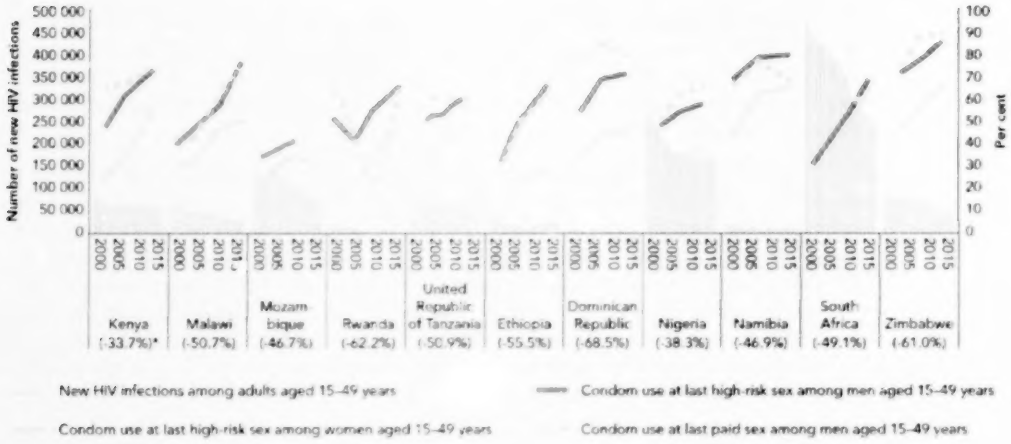
[3] Kate Grabowski and others, "HIV prevention efforts and incidence of HIV in Uganda", *New England Journal of Medicine*, vol. 377, No. 22 (30 November 2017).

15. Male and female condoms are effective, cheap and easy to use. Survey data show that increases in condom use by people at higher risk of acquiring HIV coincides with declines in HIV infections (see figure V). Condoms also prevent other sexually transmitted infections and unintended pregnancy. A recent analysis of investment costs and the potential returns of condom programmes concluded that investing an additional $27.6 billion over 15 years in male condoms as part of a package of contraceptives in 81 countries could prevent 700 million sexually transmitted infections, 17 million HIV infections and 420 million unintended pregnancies between 2015 and 2030, averting a total of 240 million disability-adjusted life years at a cost of $ 115 per disability-adjusted life year.[4]

16. The 2016 Political Declaration commits Member States to ensuring the availability of 20 billion condoms in low- and middle-income countries. The estimated condom need in 47 countries in sub-Saharan Africa in 2015 was 6 billion male condoms; however, only an estimated 2.7 billion condoms were distributed in sub-Saharan Africa in 2015, indicating that more than half of the condom need was not met.[5] Since then, several countries have strengthened their national condom programmes. Malawi, Nigeria, Uganda and the United Republic of Tanzania have developed new condom strategies; Botswana, Namibia and South Africa have increased domestic funding; and Benin, Burkina Faso, Ethiopia, Haiti, Kenya, Madagascar, Nigeria, Rwanda and Zimbabwe have worked with international partners to mobilize funding for condom programming.

Figure V

Condom use at last high-risk sex and new HIV infections, adults (aged 15–49 years), 11 countries, 2000–2016



Source: UNAIDS 2017 estimates, and population-based surveys, 2000–2016.

17. Needle-syringe programmes, opioid substitution therapy, HIV testing and antiretroviral therapy are key components of the United Nations-recommended comprehensive package of services for preventing the spread of HIV and reducing

[4] John Stover and others, "The case for investing in the male condom", *PLoS ONE*, vol. 12, No. 5 (16 May 2017).

[5] Henk Van Renterghem and others, "Estimating condom needs and gaps for fast-tracking people-centred condom programming in sub-Saharan Africa", poster prepared for the AIDS 2016 conference, held in Durban, South Africa, from 18 to 22 July 2016, session D73 (condom and lubricant availability, accessibility, distribution and social marketing).

other harms associated with drug use. Countries that have adopted a comprehensive approach to harm reduction are delivering better health outcomes for people who inject drugs and their sexual partners, including reductions in HIV and hepatitis infections and more effective management of drug use and drug-related crime.

18. Oral PrEP is an additional HIV prevention option for people at high risk of HIV infection. In several cities in North America and Western Europe, including London, San Francisco and Washington, D.C., the addition of PrEP is contributing to declines in new cases of HIV. As of June 2017, some level of PrEP access had been reported in more than 60 countries, at least twice as many as in 2016, but the number of people accessing PrEP globally remains far below the General Assembly target of 3 million by 2020. The number of people who started on PrEP between 2012 and early 2017 has been estimated at nearly 250,000. Of these, the majority (220,000) were in the United States of America.

19. Voluntary medical male circumcision is a cost-effective, one-time intervention that provides lifelong partial protection against female-to-male HIV transmission. The General Assembly committed to reaching an additional 25 million men with voluntary medical male circumcision in high-incidence countries by 2020. Efforts to voluntarily circumcise men in 14 priority countries in East and Southern Africa accelerated rapidly from 2008 to 2014, reaching 3.2 million circumcisions per year. In 2015 and 2016, however, the annual number of circumcisions fell to about 2.6 million. Achieving the target requires circumcising an average of 5 million men per year between 2016 and 2020.

Commitment 4
Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV and key populations

20. Gender inequalities and harmful gender norms undermine women's economic independence, subject women to violence and sexual abuse, deny women control over their sexual and reproductive lives and increase their risk of HIV acquisition. A systematic review of 41 studies has shown that women who experience intimate partner violence are on average 1.5 times more likely to be living with HIV than women who do not.[6] Violence, or the fear of violence, limits the ability of women to insist on safer sex and to benefit from HIV prevention and treatment interventions, or from sexual and reproductive health services. Other research shows that food insecurity is associated with increased sexual risk through transactional sex and inability to negotiate safer sex, and is a barrier to treatment initiation and adherence among women living with HIV.[7]

21. Women's heightened risk of HIV in high-prevalence settings is magnified at younger ages. In sub-Saharan Africa, adolescent girls and young women aged 15–24 years accounted for 23 per cent of new HIV infections in 2016, compared with 11 per cent of new infections for boys and young men in the same age group. Increasing attention has been paid to the role that age-disparate relationships may play in this gender imbalance. Studies conducted in a variety of settings have suggested that larger age differences among partners are associated with lower condom use and higher rates of sexually transmitted infections among adolescent girls and young women.

[6] WHO, London School of Hygiene & Tropical Medicine and South African Medical Research Council, *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva, WHO, 2013).

[7] Elisabeth Chop and others, "Food insecurity, sexual risk behavior, and adherence to antiretroviral therapy among women living with HIV: a systematic review", *Health Care for Women International*, vol. 38, No. 9 (published online 11 July 2017).

22. Despite these challenges, women living with HIV are more likely than men to access HIV testing, initiate antiretroviral therapy and adhere to treatment. As a result, men are more likely than women to die of AIDS-related causes. This imbalance is particularly large in sub-Saharan Africa, where men accounted for 41 per cent of people living with HIV and 53 per cent of AIDS-related deaths in 2016.

23. Continuing stigmatization of people living with or at risk of HIV drives acts of discrimination in all sectors of society: from public officials, police officers and health-care workers, to the workplace, schools and communities. In many countries, discriminatory laws and policies reinforce an environment of violence and marginalization, discouraging people from accessing health-care services, including HIV prevention methods, learning their HIV status, enrolling in care and adhering to treatment. Studies on stigmatization and discrimination and health-seeking behaviour show that people living with HIV who perceive high levels of HIV-related stigmatization are 2.4 times as likely to delay enrolment in care until they are very ill.[8]

24. Stigmatization of key populations at high risk of HIV infection is reinforced by criminal laws and other structural barriers, which in turn fuel violence, exploitation and a climate of fear that hinders efforts to provide condoms, harm reduction and other primary prevention methods at sufficient levels of coverage. Often, such violence is carried out with impunity. The prevalence of violence experienced by sex workers, men who have sex with men and people who inject drugs is often high, but varies by country. Among men who have sex with men recently surveyed in 17 countries, for instance, the percentage who had experienced physical violence in the previous 12 months ranged from 2.6 per cent in Colombo to 61.7 per cent in Kampala; more than half of people who inject drugs surveyed in Pakistan and female sex workers surveyed in seven locations across South Africa reported experiencing physical violence in the previous 12 months.[9]

Commitment 5
Ensure young people have the skills, knowledge and capacity to protect themselves from HIV and have access to sexual and reproductive health services

25. Young people are the future of humanity. The success of the Agenda for Sustainable Development will in large part be determined by young people's ability to access education, health care, employment and social services. In the 2016 Political Declaration, Member States committed to ensuring that that 90 per cent of young people have the skills, knowledge and capacity to protect themselves from HIV; to providing universal access to quality, affordable and comprehensive sexual and reproductive health-care and HIV services, information and commodities, including prevention commodities that are controlled by women; and to meeting a global target of reducing new infections among young women (aged 15–24) to less than 100,000 by 2020.

26. The latest available data show that young people often lack the knowledge required to protect themselves from HIV and that they underestimate their risk of infection. In sub-Saharan Africa, population-based survey data from 35 countries show that only 36 per cent of young men and 30 per cent of young women (aged 15–24) correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission. In 23 countries outside of sub-Saharan Africa, just 13.8 per cent of young men and 13.6 per cent of young women had correct and comprehensive knowledge about HIV.

[8] Hailay Abrha Gesesew and others, "Significant association between perceived HIV related stigma and late presentation for HIV/AIDS care in low and middle-income countries: a systematic review and meta-analysis", *PLoS ONE*, vol. 12, No. 3 (30 March 2017).

[9] Integrated biological and behavioural surveillance reports, 2011–2016.

27. Insufficient access to education can increase young people's HIV risk. Population-based surveys conducted in sub-Saharan Africa suggest that early sexual debut is most common among least educated girls aged 15–19 years. Adolescent girls who drop out of school are more likely to marry before the age of 18 years,[10] and child brides are often unable to negotiate safer sex, leaving them vulnerable to sexually transmitted infections, including HIV.[11] Laws that require young people under the age of 18 to obtain parental consent to access HIV and sexual and reproductive health services are barriers in many countries. Of the 106 countries that provided data to UNAIDS in 2017 on age of consent laws, 29 per cent required parental consent for a child under 18 to access HIV testing, 25 per cent required parental consent for HIV treatment and 28 per cent required parental consent to access sexual and reproductive health services.

28. Between 2010 and 2016, new infections among young women aged 15–24 years declined by 17 per cent, from 430,000 [270,000–550,000] to 360,000 [210,000–470,000]. Hitting the global target will require greater efforts to improve HIV awareness among young people and remove the barriers between them and services.

Commitment 6
HIV-sensitive social protection

29. Social protection programmes are increasingly recognized as enablers of improved HIV prevention and treatment outcomes. For example, a study in South Africa showed that social protection provisions, including nutritional support of two meals a day and attendance of an HIV support group, were associated with improved treatment adherence.[12] Multiple studies have shown that cash transfers enable girls to remain in school and that they also empower women, reduce intimate partner violence and contribute to safer sexual health — all outcomes that can support more equitable social and economic development and reduce HIV vulnerability and risk. Country data reported to UNAIDS show that cash transfer programmes feature in 10 countries in East and Southern Africa and six countries in Latin America, but that they are rarer in other regions.

Commitment 7
Community-led service delivery

30. The hands-on involvement of community-based organizations and community health workers is a hallmark of successful HIV responses, enabling public health systems to deliver services more widely and equitably. As well as expanding access to HIV services, community-based organizations provide broader services, including legal literacy, legal aid and social care. These efforts help build a stronger and more resilient civil society that can better advocate for the rights of marginalized groups.

31. Community distribution of antiretroviral medicines and the concept of differentiated care has proven highly effective in expanding the reach of HIV treatment programmes and improving their outcomes. Differentiated care is a people-centred, rights-based approach that incorporates concepts such as simplification, task shifting, decentralization and increased spacing of appointments, which facilitate more effective allocation of resources, provide better access to services for underserved populations and deliver care in ways that improve quality of care and

[10] United Nations Population Fund, *Marrying Too Young: End Child Marriage* (New York, 2012). Available from http://www.unfpa.org/sites/default/files/pub-pdf/MarryingTooYoung.pdf.

[11] United Nations Children's Fund, "Ending child marriage: progress and prospects" (New York, 2014). Available from http://www.unicef.org/media/files/Child_Marriage_Report_7_17_LR..pdf.

[12] Lucie Cluver and others, "Achieving equity in HIV-treatment outcomes: can social protection improve adolescent ART-adherence in South Africa?", *AIDS Care*, vol. 28, No. 2 (2016).

life. In 2016, 25 of 118 countries that reported data to UNAIDS had a national policy promoting community delivery of antiretroviral therapy, including 40 per cent of reporting countries in East and Southern Africa.

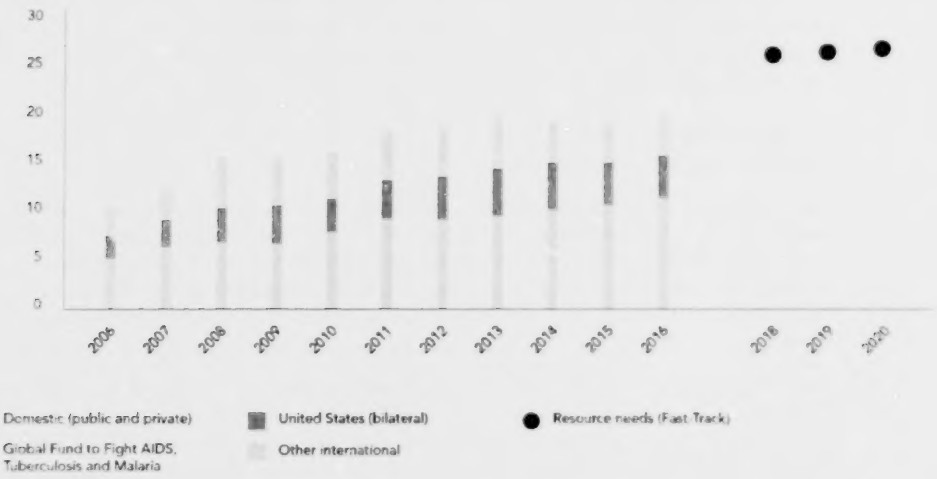
Commitment 8
Increase HIV investments

32. Resource availability for the global AIDS response is falling short of the commitment made in the 2016 Political Declaration. Total resource availability for AIDS responses in low- and middle-income countries in 2016 remained flat for the third consecutive year, at about $19.1 billion. Within this stable aggregate trend, international investment peaked in 2013 at nearly $10 billion (in constant 2016 United States dollars) and then declined to around $8.1 billion in 2016. Domestic investment by low- and middle-income countries, meanwhile, increased by an average of 11 per cent a year from 2006 to 2016; however, the rate of that increase slowed to 5 per cent between 2015 and 2016 (see figure VI).

33. This overall stable trend in resource availability is at odds with the commitment of investing $26 billion in the AIDS responses of low- and middle-income countries by 2020. Building on the unprecedented international assistance made available by the United States President's Emergency Plan for AIDS Relief (PEPFAR) and through the Global Fund to Fight AIDS, Tuberculosis and Malaria, additional domestic and donor investment is needed to achieve the fast-track targets for 2020.

Figure VI
HIV resource availability by source, 2006–2016, and projected resource needs by 2020, low- and middle-income countries

(Billions of United States dollars)



Source: UNAIDS estimates June 2017 on HIV resource availability; UNAIDS, "Fast-track update on investments needed in the AIDS response" (Geneva, 2016); Jen Kates and others, "Donor Government funding for HIV in Low- and Middle-Income Countries in 2016" (The Henry J. Kaiser Family Foundation and UNAIDS, 2017); *Global AIDS Monitoring* reports and Global AIDS Response Progress Reporting (2005–2017); and Funders Concerned about AIDS, "Philanthropic support to address HIV/AIDS in 2015" (Washington, D.C., 2016).

Note: Estimates for low- and middle-income countries as per 2015 World Bank income level classification. All figures are expressed in constant 2016 United States dollars.

Commitment 9
Empower people living with, at risk of and affected by HIV

34. Data from population-based surveys conducted between 2011 and 2016 in 47 countries across seven regions show wide variations in the percentage of people expressing discriminatory attitudes towards people living with HIV (see figure VII). Countries where multiple surveys have been conducted show declines over time. In East and Southern Africa, for instance, the percentage of people who would not buy vegetables from a shopkeeper living with HIV declined from 53.8 per cent in 2003–2008 to 36.2 per cent in 2010–2016. In West and Central Africa, the decline in discriminatory attitudes has been less marked, from 62 per cent in 2003–2008 to 50.7 per cent in 2010–2016. Overall, discriminatory attitudes persist globally: half of men and women (aged 15–49 years) in the 47 countries where surveys were conducted indicated that they would not buy vegetables from a shopkeeper living with HIV.

Figure VII
Percentage of men and women aged 15–49 years who would not purchase vegetables from a shopkeeper living with HIV, countries with available data, 2011–2016

[illegible]	[illegible]	[illegible]	[illegible]
Egypt*	Afghanistan	Bangladesh*	Argentina*
Guinea	Benin	Belize	Barbados*
Iraq*	Bosnia and Herzegovina	Cameroon	Botswana
Jordan*	Comoros	Chad	Cambodia
Yemen*	Ethiopia	Congo	Cuba
	Gambia	Costa Rica*	Kenya
	Ghana	Côte d'Ivoire	Lesotho
	Haiti	Democratic Republic of the Congo	Malawi
	Indonesia	Dominican Republic	Namibia
	Jamaica	Gabon	Rwanda
	Kazakhstan	Honduras	Zambia
	Kyrgyzstan	Mali	Zimbabwe
	Lao People's Democratic Republic	Mozambique	
	Liberia	Nepal	
	Mauritania*	Nigeria	
	Montenegro	Pakistan	
	Myanmar	Peru*	
	Niger	Togo	
	Republic of Moldova	Uganda	
	Senegal	Viet Nam*	
	Sierra Leone		
	Tajikistan*		
	Tunisia*		
	Ukraine		

Source: Population-based surveys, 2011–2016.
* Female respondents only.

35. Populations at increased risk of HIV infection also face high levels of stigmatization owing to, among other things, their gender, sexual orientation, gender identity, drug use or sex work. In many countries, laws and policies reinforce an environment of violence and marginalization, which hinders access to services and can increase food insecurity. Civil society organizations and academic institutions

have reported that 72 countries criminalize same-sex sexual activity,[13] with 32 countries retaining the death penalty for drug offences[14] and over 100 countries criminalizing some aspect of sex work.[15] Among countries that reported data to UNAIDS in 2017, 44 out of 100 reported that they had laws specifically criminalizing same-sex sexual activity; 17 out of 116 countries reported that they criminalized or prosecuted transgender people; and 84 out of 110 countries reported that they criminalized some aspect of sex work. Regarding drug use or possession of drugs, 78 out of 90 countries reported that drug use or possession of drugs for personal use was a criminal offence or grounds for compulsory detention, and 9 out of 107 countries reported that they imposed the death penalty for drug-related offences.

36. Reforming or removing discriminatory and punitive laws and implementing protective legal norms empowers individuals and communities, providing an environment where people feel they can access health services safely, with dignity and on an equal basis with others. When same-sex sexual behaviour and relationships are not punishable by law, gay men and other men who have sex with men and transgender people are better enabled to seek out the health care and other services they need. In countries that have implemented full or partial decriminalization of drug use, such as Czechia and Portugal, there have been tangible impacts on addiction, drug-related crime, drug-related deaths and HIV transmission. A recent study among 27 European countries concluded that countries that had legalized some aspects of sex work saw significantly lower HIV prevalence among sex workers than those which criminalized all aspects of sex work.[16] Actively protecting the rights of marginalized populations is essential to the mitigation of societal stigmatization and discrimination. This includes laws that do the following: prohibit discrimination on the basis of HIV status, sexual orientation and gender identity in health-care settings and elsewhere; create systems for handling and investigating complaints of discrimination; and protect the confidentiality of personal information and the right to consent to treatment.

37. There are often significant barriers to accessing justice systems. Accessible and affordable legal representation is critical. Legal access programmes that combine health services and legal aid have proven particularly effective. In several countries, community advisory boards have given people greater opportunity to communicate grievances and seek legal redress.

Commitment 10
Taking AIDS out of isolation

38. Taking the HIV response further out of isolation can accelerate progress across the Sustainable Development Goals. The overlapping epidemics of HIV, tuberculosis, viral hepatitis and human papillomavirus (HPV) have similar challenges and features, including modes of transmission, diagnostic difficulties and affected populations that are hard to reach. Improved collaboration among health programmes can strengthen health systems and improve efficiency. The 2016 Political Declaration explicitly recognizes these linkages, calls for national health systems to address co-infections

[13] Aengus Carroll and Lucas Ramón Mendos, *State-Sponsored Homophobia: A World Survey of Sexual Orientation Laws — Criminalisation, Protection and Recognition*, 12th ed. (Geneva, International Lesbian, Gay, Bisexual, Trans and Intersex Association, 2017).

[14] Harm Reduction International, Death Penalty Project (web page). Available from https://www.hri.global/death-penalty-project. (Accessed 14 September 2017).

[15] Cheryl Overs, Sex Work Law Map (web page), created for the Institute of Development Studies. Available from http://spl.ids.ac.uk/sexworklaw. (Accessed 20 September 2017).

[16] Aaron Reeves and others, "National sex work policy and HIV prevalence among sex workers: an ecological regression analysis of 27 European countries", *The Lancet HIV*, vol. 4, No. 3 (24 January 2017).

and co-morbidities with integrated approaches and includes commitments to dramatically reduce hepatitis B and C infections and increase treatment coverage for tuberculosis and hepatitis.

39. Major gains have been made over the past decade in the global response to tuberculosis among people living with HIV. In 2004, just 3 per cent of notified tuberculosis patients were aware of their HIV status, and 54 per cent of tuberculosis patients living with HIV were accessing antiretroviral therapy. In 2016, 57 per cent of notified tuberculosis patients were aware of their HIV status, and 85 per cent of tuberculosis patients living with HIV were accessing antiretroviral therapy. Tuberculosis-related deaths among people living with HIV have declined by more than one third, from a peak of about 593,000 in 2007 to 374,000 in 2016. Tuberculosis preventive treatment is also expanding, especially in the two priority risk groups of people living with HIV and children under 5. Close to 1 million people living with HIV newly enrolled in HIV care in 2016 received tuberculosis preventive treatment in 60 countries, compared with 12,000 reported by just three countries in 2004.

40. Despite these impressive gains, the 28 per cent decline in tuberculosis-related deaths among people living with HIV since 2010 falls considerably short of the 2020 target of 75 per cent set by Member States in the 2016 Political Declaration. Tuberculosis also remains the leading cause of hospital admission and mortality among people living with HIV, accounting for more than one third (37 per cent) of all AIDS-related deaths in 2016, and the ninth leading cause of death worldwide. The number of notified tuberculosis cases among people living with HIV in 2016 was only 46 per cent of the estimated total number of people living with HIV who fell ill with tuberculosis that year, highlighting a considerable gap in timely diagnoses and high rates of tuberculosis among people living with HIV who are not yet accessing antiretroviral therapy. Closing this gap and screening all people living with HIV in care for the presence of tuberculosis symptoms, as called for in the 2016 Political Declaration, will require national tuberculosis and HIV programmes to better collaborate on index case contact tracing, community outreach and adherence support activities.

41. Drug-resistant tuberculosis is a continuing threat to progress. In 2016, there were 600,000 new cases with resistance to rifampicin, the most effective first-line drug, of which 490,000 cases involved multidrug-resistant tuberculosis. Broader influences on the tuberculosis epidemic include levels of poverty, undernutrition and smoking. To reach the tuberculosis-related 2020 milestone targets in the 2016 Political Declaration, such as reaching 90 per cent of all people who need tuberculosis treatment, including 90 per cent of populations at higher risk, and achieving at least 90 per cent treatment success, declines in tuberculosis incidence and tuberculosis deaths need to improve to 4–5 per cent per year, and the percentage of tuberculosis cases that result in tuberculosis-related deaths must fall from 16 per cent to 10 per cent.

42. Among the 36.7 million persons living with HIV in 2015, an estimated 2.7 million had chronic infection with the hepatitis B virus and 2.3 million had been infected with the hepatitis C virus. The hepatitis targets within the 2016 Political Declaration are to reduce new cases of chronic viral hepatitis B and C infections by 30 per cent by 2020; to ensure that 5 million people receive hepatitis B treatment by 2020; and to ensure that 3 million people with chronic hepatitis C infection are treated by 2020. In 2016, 4.5 million people were on hepatitis B treatment and 1.76 million started hepatitis C treatment. The effective scaling up of the hepatitis B vaccine — global coverage with the three doses of hepatitis B vaccine in infancy reached 84 per cent in 2015 — has substantially reduced hepatitis B transmission in the first five years of life, contributing to a reduction in the prevalence of hepatitis B among children to 1.3 per cent.

43. Other prevention interventions are available but insufficiently implemented. The provision of effective harm reduction services, including needle-syringe programmes that prevent transmission of hepatitis C (and of HIV) among people who inject drugs, has been inadequate. As a result, an estimated 1.75 million new hepatitis C infections occurred worldwide in 2015. Access to affordable hepatitis testing is also limited and, among those diagnosed, treatment has reached only a small fraction. Worryingly, deaths caused by viral hepatitis are on the increase, rising from 1.10 million in 2000 to 1.34 million in 2015.

44. Several "early adopter" countries, including Egypt, Georgia, Mongolia and Pakistan, are showing that rapid scale-up of hepatitis C testing and treatment can be achieved through committed political leadership and a reduction in the prices of essential medicines and diagnostics to expand testing and treatment services. Expanding the scope of viral hepatitis prevention, testing and treatment requires a public health approach to delivering services for all in need, within a framework that delivers the sustainable financing required for universal health coverage.

45. Women living with HIV are at four to five times greater risk of developing cervical cancer. This risk is linked to HPV, a common infection among sexually active men and women that is difficult for women with compromised immune systems (such as women living with HIV) to clear. Minimizing deaths from cervical cancer requires a comprehensive approach. Because HPV infection is common at younger ages, a key strategy is early vaccination of adolescent girls, before sexual exposure. HPV immunization programmes to date have been predominantly in high-income countries. Of the estimated 118 million women that HPV immunization programmes sought to reach between June 2006 and October 2014, only 1 per cent were from low-income or lower-middle-income countries.

II. The AIDS response and United Nations reform

46. The Joint United Nations Programme on HIV/AIDS was established by the Economic and Social Council in its resolution 1994/24 to lead and inspire the world in achieving universal access to HIV prevention, treatment, care and support at a time when the collective response was failing. More than two decades later, UNAIDS is coordinating the efforts of 11 United Nations entities and works in close partnership with Member States, civil society, the Global Fund, PEPFAR, academia and the private sector. These efforts have united the world behind a global goal to end the AIDS epidemic as a public health threat by 2030.

47. The Joint Programme has steadily evolved over the past two decades, growing from 6 to 11 co-sponsoring United Nations agencies. Co-sponsors and the Secretariat have a joint six-year strategy and a unified budget, workplan and accountability framework for their HIV-related work. Joint United Nations teams on AIDS led by UNAIDS country directors are consistently strong performers within United Nations country teams. Civil society plays an active role in UNAIDS governance, and dynamic partnerships among Member States, the United Nations system, civil society and the private sector are a defining quality of successful AIDS responses in low- and middle-income countries. Within the international partnership against AIDS and supported by UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria has played a critical role in the alignment of development financing behind national investment cases for AIDS responses that are underpinned by epidemiological and programme evidence and guided by strong results frameworks.

48. In 2017, UNAIDS convened a multi-stakeholder expert panel to provide recommendations on refining and reinforcing the Joint Programme within the context of an evolving epidemic and United Nations reform. The panel made specific

recommendations on the deployment of human and financial resources, on the reinvigoration of country-level joint work and on the reinforcement of accountability and results for people. These recommendations were translated into an action plan approved by the UNAIDS Programme Coordinating Board in June 2017. Since then, UNAIDS has conducted assessments of its capacity at the country level and rolled out a revised resource allocation model featuring "country envelopes" of financial resources that are programmed by joint United Nations teams on AIDS and agreed by United Nations country teams in 71 priority countries. This ongoing refinement of the UNAIDS operating model and realignment of staff and financial resources are aimed at ensuring that the United Nations remains fit for purpose as it supports each phase of the AIDS response. The UNAIDS approach as envisioned by the Economic and Social Council — its achievements, lessons learned and proactive evolution — can inform work in several of the proposed areas of repositioning the United Nations development system to better support the achievement of the 2030 Agenda. The UNAIDS experience is of direct relevance to the reformed United Nations vision that is aimed at addressing duplication and filling gaps through joint work based on leveraging entity-specific comparative advantage. The joint and co-sponsored model has demonstrated that strengthened partnerships in general, and a cohesive and integrated approach at the country level, expand and strengthen the offer of critical "whole of system" support to countries.

III. Recommendations

49. Ending AIDS as a public health threat by 2030, as called for in the 2030 Agenda, remains within sight. Nevertheless, slow progress on reductions in new infections point to gaps and challenges that must be addressed if we are to achieve our ultimate goal. Despite the existence of so many evidence-informed options to prevent HIV infections, few countries have established robust, combination prevention strategies and made sufficient investments to ensure that such strategies are implemented. National laws and policies fail to protect society's most vulnerable members. Millions of women, children, newborns and adolescents continue to die every year, mostly from preventable causes. Young women remain at unacceptably high risk of HIV infection in high-prevalence settings, and on all continents there are insufficient efforts to reach key populations at higher risk of infection, migrants and people living in humanitarian settings with the services they need to prevent, diagnose and treat HIV.

50. AIDS is not over, but it can be. Achieving all the fast-track targets by 2020 requires Member States to adopt a location-population and life-cycle approach that fully leverages surveillance and programme data, that ensures that every person in need has knowledge of and access to multiple effective prevention options, HIV testing and treatment services, and that establishes the legal protections necessary for every person in need to be able to utilize those services.

Recommendation 1
Mobilize an HIV testing revolution and achieve the 90–90–90 targets

51. The gaps across the HIV testing and treatment cascade have narrowed, but when combined they translated to 44 per cent [32–53 per cent] of all people living with HIV being virally suppressed in 2016 — substantially lower than the 73 per cent required for full achievement of the 90–90–90 targets. The biggest gap is the first step of the cascade: knowledge of HIV status. An unacceptable proportion of people living with HIV, especially young people, men and key populations, are unaware of their HIV status, and unable to access treatment and protect their partners from HIV infection. As a result, the percentage of patients who receive a diagnosis several years after

acquiring HIV and have advanced disease at treatment enrolment remains alarmingly high in many countries.

52. Member States are urged to join an HIV testing revolution that will ensure achievement of the 90–90–90 targets by 2020. Scaling up early infant and child diagnosis and accelerating the development and rollout of paediatric antiretroviral formulations is critical to achieving the global target of 1.6 million children living with HIV accessing antiretroviral therapy by the end of 2018. Point-of-care mechanisms for early infant diagnosis hold particular promise, as do efforts to ensure that all adults in HIV care have testing offered to their children, and to offer HIV testing to young children presenting for immunizations, malnutrition services and tuberculosis treatment. Member States should ensure that the latest HIV testing innovations are widely available to the people and places in greatest need. These innovative testing approaches include community-based testing, self-testing and assisted partner notification.

Recommendation 2
Accelerate efforts to end tuberculosis and other co-infections and co-morbidities

53. The WHO Global Ministerial Conference on Ending Tuberculosis in the Sustainable Development Goal Era, held in Moscow in November 2017, concluded with a collective commitment to move rapidly to achieve universal health coverage, including through the scale-up of integrated, people-centred tuberculosis and HIV services through collaborative activities. The first-ever high-level meeting of the General Assembly on tuberculosis, to be held in September 2018, provides a historic opportunity to galvanize this commitment into an actionable General Assembly declaration, to accelerate the response to tuberculosis and HIV-associated tuberculosis and to put individual countries and the world firmly on the path to ending tuberculosis deaths among people living with HIV. This will require the closing of a $2.3 billion funding gap through both domestic sources (especially in middle-income countries) and international donors (especially in low-income countries). The third high-level meeting on the prevention and control of noncommunicable diseases is another opportunity to make global health gains that will have a positive impact on the HIV response. Both of these meetings, as well as the 2019 high-level meeting on universal health care, provide opportunities to link issues across the global health agenda, aligning programming and financing efforts for greater efficiency gains while encouraging stronger whole-of-system approaches for health.

54. Beyond tuberculosis, specific steps to address co-infections and co-morbidities are the continued scaling up of hepatitis B and C treatment, including through procuring high-quality generic medications, developing new laboratory technologies for testing different conditions using a common platform for disease-specific tests, e.g. HIV and syphilis, and ramping up HPV vaccination, education, screening and treatment. Improving primary health-care access will accelerate disease-specific responses. Anti-poverty measures will have a similar impact. Taking AIDS further out of isolation requires accelerated efforts towards the global goal of achieving universal health coverage by 2030 and broader efforts to achieve the 2030 Agenda. Again, the 2019 high-level meeting on universal health care provides an opportunity for Member States to situate HIV and AIDS squarely at the centre of the discussion, both as a driver for and a beneficiary of universal health care.

Recommendation 3
Use the HIV prevention road map to accelerate reductions in new infections

55. All low- and middle-income countries, and especially the 25 countries where nearly 75 per cent of new HIV infections occurred in 2016, are urged to use the HIV prevention road map to take immediate concrete steps to accelerate progress towards

their 2020 commitments on HIV prevention using evidence-informed, people-centred and rights-based approaches. The 10-point plan within the road map guides countries to (a) conduct a strategic assessment of key prevention needs and identify policy and programme barriers to progress; (b) develop or revise national targets and road maps for HIV prevention; (c) make institutional changes to enhance HIV prevention leadership, oversight and management; (d) introduce the necessary legal and policy changes to create an enabling environment for prevention programmes; (e) develop national guidance, formulate intervention packages, identify service delivery platforms and update operational plans; (f) develop a consolidated capacity-building and technical assistance plan with regard to prevention; (g) establish or strengthen social contracting mechanisms for civil society implementers and expand community-based responses; (h) assess available resources for prevention and develop a strategy to close financing gaps; (i) establish or strengthen monitoring systems for prevention programmes; and (j) strengthen national and international accountability for prevention. Critical programmatic actions include more urgent expansion of condom programmes, harm reduction, voluntary medical male circumcision and oral PrEP. Legal and policy changes must focus on lifting the structural and policy barriers to access to services among most at-risk and vulnerable groups, including young people in and out of school and key populations, reducing stigmatization and discrimination and providing those groups with equitable access, thereby ensuring the progressive realization of their human rights.

Recommendation 4
Safeguard human rights and promote gender equality through people-centred service delivery models and supportive legal and policy frameworks

56. The AIDS response was built through activism: a demand for services among people living with HIV grounded in a human rights approach. A large body of evidence shows that the establishment of people-centred service delivery models, supportive legal and policy frameworks, monitoring and enforcement mechanisms, and sensitization training for health-care workers and other duty bearers can promote inclusion and achieve equal access to health services. Gender equality, including keeping girls in school and addressing violence against women, is critical to empowering women and girls to protect themselves from HIV infection. The removal of consent requirements is required to accelerate service access among young people, and the removal of discriminatory laws and policies and equal access to legal aid is critical to guarding the rights of key populations and people living with HIV. Member States are urged to promote and protect all human rights and fundamental freedoms and to redouble their efforts to fulfil their commitments in the 2016 Political Declaration to achieve gender equality; to intensify national efforts to create enabling legal, social and policy frameworks that promote non-discriminatory access to HIV services, education, health care, employment and social services; and to provide legal protections for people living with, at risk of and affected by HIV.

Recommendation 5
Leverage the UNAIDS joint programme and the H6 partnership as global health accelerators and incubators for United Nations reform

57. The joint United Nations approach to AIDS is increasingly relevant as the United Nations enters a critical period of reform amid evolving global security threats, humanitarian emergencies, development challenges and climate change. Both development and humanitarian actors must collectively build on the gains made in the response to HIV to date while at the same time adapting to the changing political, economic and epidemiological contexts. Full support of the UNAIDS joint programme action plan and the strategic resource mobilization plan for the period

2018–2021 by Member States is critical to ensuring that UNAIDS remains on the forefront of United Nations reform.

58. The chairmanship of the H6 partnership by UNAIDS is an opportunity to leverage the joint programme's experience and accelerate reform of the United Nations development system. Many of the priorities of the United Nations reform agenda — joint working, reducing fragmentation and duplication, generating strategic information, delivering integrated policy advice and strengthening accountability — are at the heart of both UNAIDS and the H6 model. Similarly to the fast-track approach to AIDS inspired by the UNAIDS six-year strategy and the 2016 Political Declaration, the H6 partnership can inspire greater ambition and political commitment to women's, children's and adolescents' health, focus joint United Nations efforts around clear deliverables and results, and accelerate progress within the context of the 2030 Agenda for Sustainable Development. Member States are urged to support the H6 partnership to serve as a global health accelerator and incubator of United Nations development system reform.